CHILDREN'S DENTAL HEALTH CLINIC
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Little Hoover Commission
Denti-Cal Hearing
September 24th, 2015

Re: Written Testimony
John Blake, D.D.S.

For background, I am a practicing general dentist. I have worked for many years in private practice and, for the past 10 years as the executive director and dental director of the Children's Dental Heatlh Clinic- a 501(c)(3) non-profit comprehensive dental treatment and teaching program in Long Beach. The Children's Dental Health Clinic (CDHC) was founded in 1932. We treat low-income patients from birth through 21 years old. We lease our main clinic space on the Miller Children's Hospital campus in Long Beach. For perspective, we completed 80,000 procedures on 20,000 patients in our last fiscal year. 85% of those patients are enrolled in the State's Denti-Cal system. We have a mobile clinic and a satellite clinic in Avalon, on Catalina Island. We recently closed our Bellflower satellite clinic due in great part to the inadequacies of the Denti-Cal system. Our main clinic in Long Beach has 15 dental operatories or treatment rooms. About 20% of all of our patients have some form of special physical/developmental and/or medical needs. We have 38 employees and 17 contracted dentists. Most of our dentists typically give us one day a week and spend the rest in their private practices. Many of our pediatric dentists were former residents in our pediatric dental training program.

The Children's Dental Health Clinic has an annual budget of just under $4,000,000. Half of our revenue comes from patient payment sources; the other half comes from foundation, corporate and individual donations and endowment/investment income. The patient payment sources are 85% Denti-Cal, 5% MHLA (an L.A. County program that mimics the Denti-Cal system), and 10% "sliding-scale"/based on the patients ability to pay. *We have to backfill half of our annual budget as working in the Denti-Cal system will not pay the bills and is a losing proposition. It makes no business sense to provide honest care in the current Denti-Cal system.* Yet, the CDHC soldiers on, as we are one of the last multi-specialty "dental homes" for children of low-income families left in our area. It is a difficult, daily struggle to continue to deliver our level of oral healthcare services to a population with increasingly fewer provider options.

Most all of my dental colleagues I speak with want to "do the right thing" and help struggling patients. Many volunteer at the well-organized "CDA Cares" free dental treatment events held throughout our state. Many used to work in the Denti-Cal system but have dropped out. The biggest reason for leaving the system is poor reimbursement. Right behind that is the administrative burden.
These same dentists would rather provide care to the poor for free than hassle with the time and effort involved with trying to recoup 26 cents on the dollar in the Denti-Cal system. With few exceptions, dentists are not greedy. They are highly trained scientists/artists/healthcare professionals that want to help patients in need but must also pay their bills.

Except for our (CDHC) program, there are currently no oral surgeons and no pediatric dentists that accept Denti-Cal patients in the greater Long Beach area. I am sure that some are still on the states list of providers but none are functionally taking Denti-Cal patients. The last oral surgeon to leave in our area called me two months ago, almost in tears, saying he could no longer do it. This is a surgeon I have worked with on many (Denti-Cal) cases in the hospital operating room- typically special needs patients; I would do the comprehensive restorative dentistry and he would do the surgical procedures (typically removal of 3rd molar/wisdom teeth and/or biopsies). He was my last "go to guy" in the area to refer difficult Denti-Cal surgical cases to. He left the system not really because of the poor reimbursement- he knew he was losing money on most all Denti-Cal cases. He left because of the onerous administrative burden, which has only increased in the last 5 years. Once covered surgical procedures now require pre-authorization, with state paid dentists second-guessing his diagnosis from notes and x-rays.

Last year, participating dentists were asked to re-enroll or signify that they no longer wished to provide care in the Denti-Cal system. Those that chose to stay in were met with a very lengthy application with odd, seemingly non-relevant questions. It took one of our staff members almost 40 hours gathering information to help our 17 dentists re-apply. This is not an efficient system and certainly does not encourage dentists to participate.

Compared to commercial insurance carriers, the Denti-Cal system is perversely challenging to navigate. Procedures that are not questioned and routinely paid by commercial carriers require pre-authorization, often delaying timely and necessary treatment. Examples are crowns, root canals and periodontal (gum) treatments. I have one full-time employee that dedicates her workweek to pre-authorizations and resubmissions.

We take pictures to document all teeth that we feel Denti-Cal may question our dentist's diagnosis. This cost our dental team precious treatment time and serves no benefit to the patient.

It is illustrative to review the history of treating the poor/needy/low income/underserved in our state and locally in our non-profit dental program. When I graduated dental school in 1988, I started a private practice but still gave the Children's Dental Health Clinic a day a week. The clinic did not take Denti-Cal at that time. Most all patients paid $20 for ½ hour of our dental team's treatment time ($40 for an hour, etc.).
Patients were appreciative of the low-cost dental care and we, as a clinic, were able to pay our bills with no needed reliance on other funding. Patients of limited means were using their own money to pay for their oral healthcare needs. They were highly incentivized to improve their children's oral health, and save money on subsequent visits. These families were truly the "working poor"; many in low wage jobs but they were trying to make ends meet and build a better life. I recall talking to many parents that were glad to come in and announce that they, reluctantly, would have to leave our clinic because they had a better job that paid more and had good dental insurance. What a lesson for their children.

In the early 1990's, we realized that there were children and young adults with disabilities and special needs that would be best treated in our hospital-based environment. They often had extensive and complex dental needs that could not be met with our $20 per ½ hour system. We signed up for Denti-Cal and CCS (a program specific for developmental/special needs patients). At the time, these patient payment systems offset the cost of treating this uniquely challenging group of patients- often under sedation or in the hospital operating room. In California, as the Medi-Cal system flourished and increased patient eligibility, we noticed more and more of our patients opting into Denti-Cal and out of our cash-based system. By 1995, over 70% of our patients used the Denti-Cal system as their dental benefit. Our mission of serving the poor had not changed, but our business model had indeed. Throughout the 1990's we increased our development/donation efforts as we realized that relying on Denti-Cal as our primary income source may not be sustainable and was spreading our margins fairly thin. By 2001, all (Denti-Cal) provider fee increases stopped and have remained at that level through today. Depending on who's doing the survey, California is around 47/50 in (lowest) provider reimbursement. Some provider offices responded by cutting costs and doing as much work as possible on patients (more billing). We responded by staying with appropriate, comprehensive dental treatment and increasing our outside funding efforts.

If say, a 4 year old needed multiple fillings and an extraction, some offices would use a general dentist; restrain the patient and "get the work done"- often traumatizing the young patient. We would use an appropriately trained pediatric dentist, hire a dental anesthesiologist to safely sedate and monitor the patient and complete all of the necessary treatment while the patient sleeps. Our route remains more labor/time intensive and certainly more expensive; *but is the correct and desirable treatment of the young patient with extensive dental disease.*

So I guess I'm now a veteran in this well intended, highly flawed system called Denti-Cal. We have created a system where now 53% of our state's children are eligible for a card that gives them access to "free" dental care. Please do not misinterpret my discontent; there are many children that would have no other access to dental care if this system were not in place.
But that access to timely, appropriate care is no longer available. The problem is that the system has been allowed to morph into its current form of dysfunction, serving neither the patient nor the provider.

The Denti-Cal system, less than 1% of the state's Medi-Cal budget, can and should be fixed.

The most obvious, and probably the most contentious legislatively, would be to increase provider rates and decrease the (participating dentist) administrative burden. I do not offer this lightly as I am quite aware of the challenges you'd face to make this happen. This is not a "dentist's want more money" route. Rather, we'd just ask that we are able to pay our bills (not profit) working in the system. If reimbursement rates were at least at the national average, most dentists would "do their part" and join the system. Other states have done this and do not have access to dental care issues. This would have to be done in tandem with a "cleaner" administrative and claims processing system similar to the commercial insurance process.

Another solution is what I have termed the "Nuclear" option. Blow the whole system up and start from scratch. What might that system look like? Give each eligible child's family a traceable card (or smartphone app) with $500 loaded annually to be used for (non esthetic/elective) dental care. They can go to any registered office of their choice and establish a dental home for their child. There would be an obvious incentive to arrest current dental disease, change destructive diet habits, keep and maintain a healthy mouth. Yes, parents may have to pay for annual dental services above the $500 limit.

Most would not want to do this every year and would have a strong incentive to maintain optimal oral health. The one exception to this program would be those patients with documented special needs/disabilities. There should still be a system of reimbursement for dentists that treat these complex patients, often under sedation or general anesthesia. It has been difficult to ascertain the true current cost of the Denti-Cal system but from the publically available numbers I found, this proposed system would be cheaper than the current one. It would also put some responsibility back with the patients/families and encourage a better dentist-patient relationship.

There are also many other emerging ideas that would augment a repaired or new Denti-Cal system. We use a form of "Tele-Dentistry" in our remote Avalon island clinic. These ideas and auxiliary providers should be encouraged and utilized. At the CDHC, we have embraced early childhood intervention and education, pioneering a 1st 5 L.A. funded program 5 years ago. This program was so successful in educating young patients and families on healthy diets and proper oral health habits that we have continued the program well past the original pilot grant.

These programs are helpful but will not solve the states oral healthcare woes by themselves. They should be adjuncts to a functional, robust system of oral healthcare. At some point, patients with dental disease will still need care with the appropriate providers, including specialists. Prevention and education are cornerstones to comprehensive care but cannot be successful without willing dental providers in a fair, functional and transparent state sponsored system.

Some of this may be a bit radical but the California I once knew used to innovate. We were a beacon of hope and ideas for other states to emulate and learn from. I have spent the better part of my professional career trying to take care of those most vulnerable in our state. These patients are our neighbors that do not need a handout but need a helping hand. The citizens of our golden state should have something to smile about. There are plenty of dentists willing to make that happen- let's get to work!

Sincerely,

John L. Blake, D.D.S.
Executive Director
Dental Director